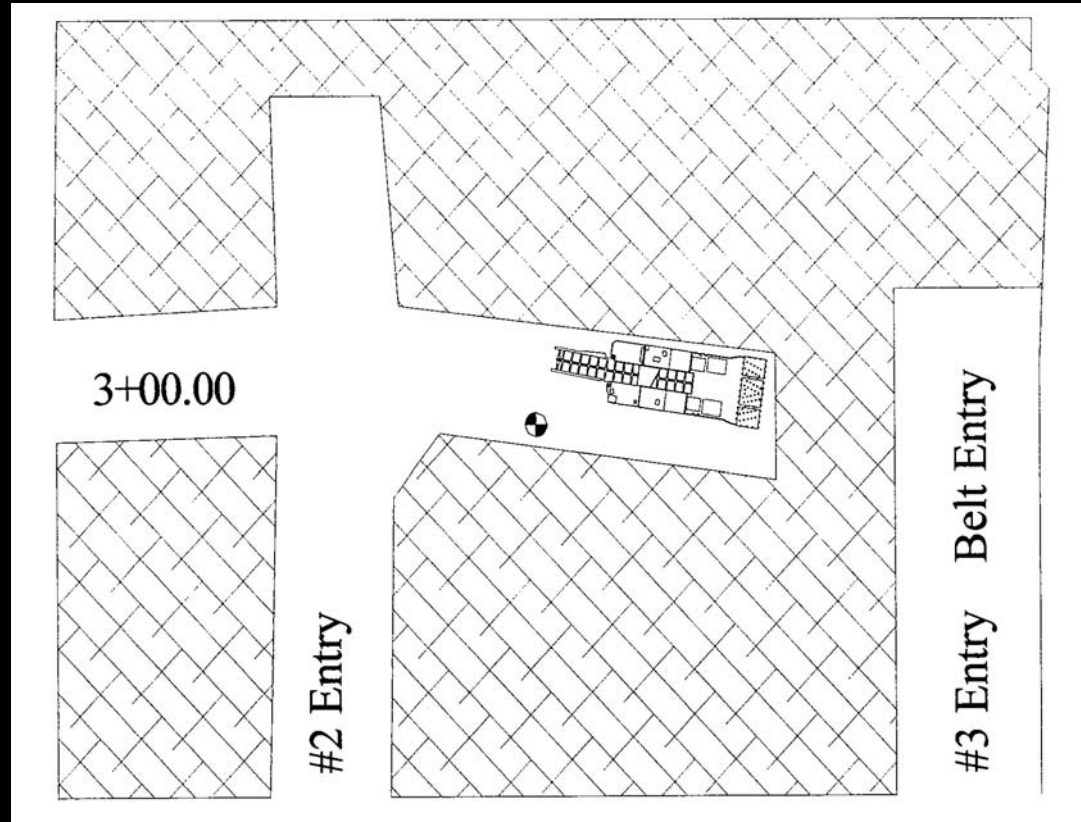


*This presentation is for illustrative and **general** educational purposes only and is not intended to substitute for the official MSHA Investigation Report analysis nor is it intended to provide the sole foundation, if any, for any related enforcement actions.*

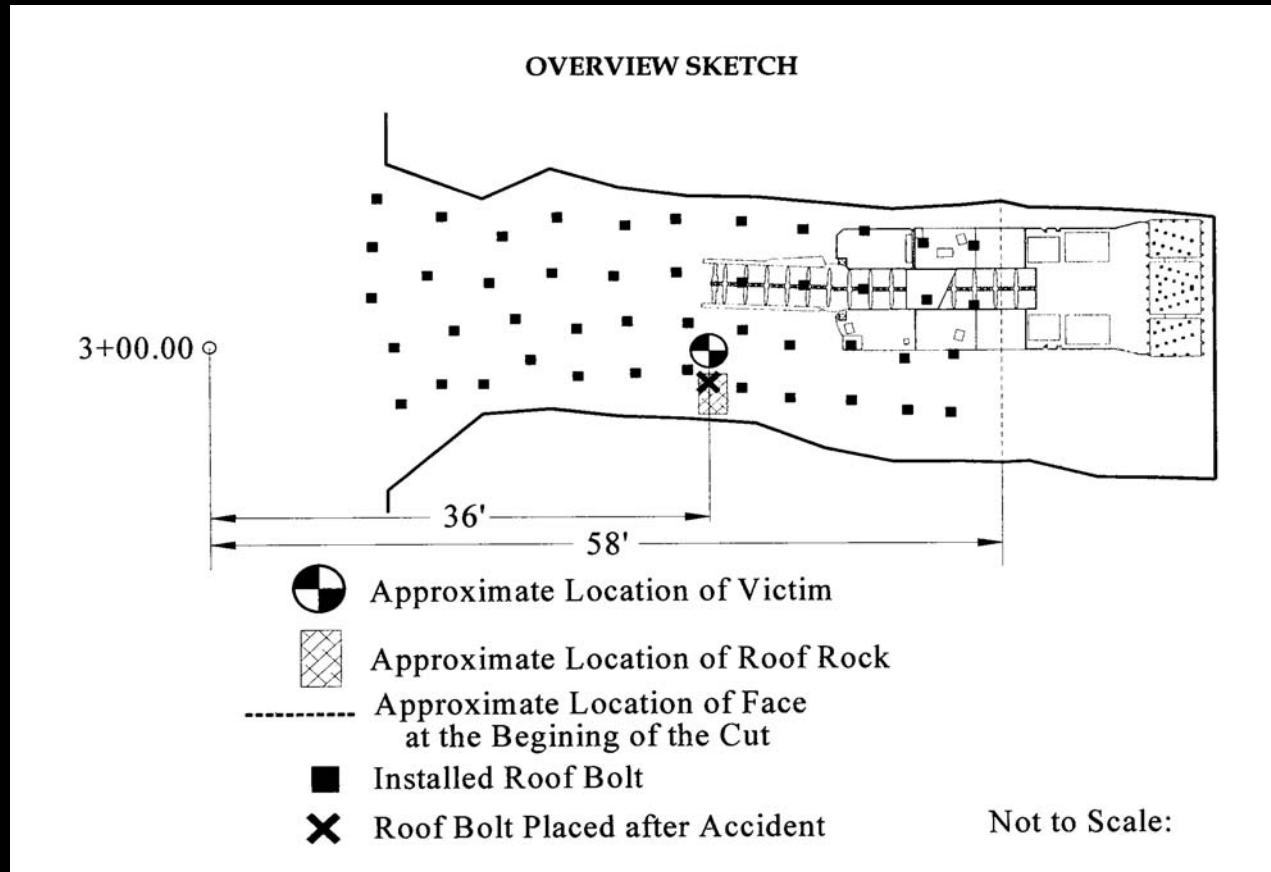
# GENERAL INFORMATION

## Coal Mine Fatal Accident 2005-17



|                 |  |
|-----------------|--|
| Operator:       | Drummond Company, Inc.                 |
| Mine:           | Shoal Creek Mine                       |
| Accident Date:  | August 10, 2005                        |
| Classification: | Roof Fall                              |
| Location:       | District 11, Jefferson County, Alabama |
| Mine Type:      | Underground                            |

# ACCIDENT DESCRIPTION

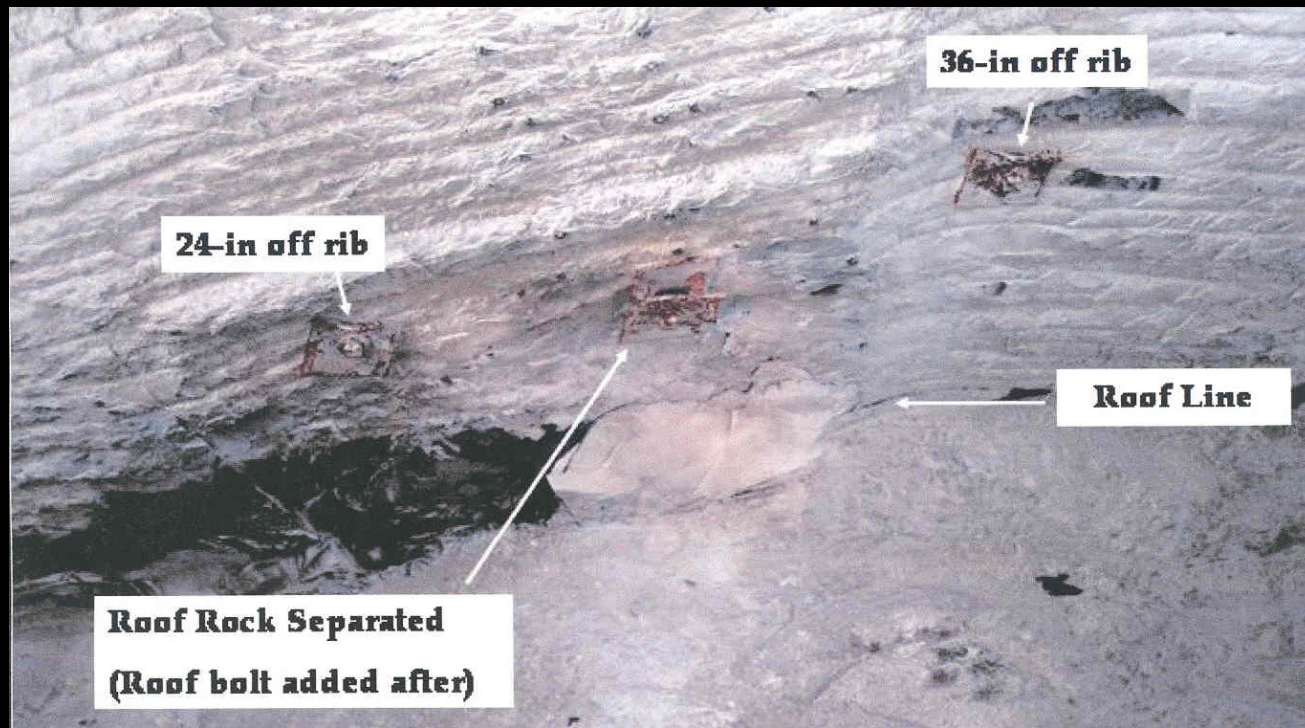


At ~ 8:00 p.m. on Thursday, August 10, a 54-year old continuous miner operator was fatally injured in a roof fall. The victim was struck by a 30" x 30" x 6" piece of roof rock that fell from between the rib and roof bolts. He was operating the continuous mining machine via radio remote control, while standing along the right rib, when the accident occurred. The victim died of his injuries on November 15, 2005. He had 1 year, 13 weeks experience in this occupation.

# ROOT CAUSE ANALYSIS

Causal Factor: A localized geologic discontinuity, exposed during mining, was not recognized and adequate precautions to eliminate the hazard were not taken.

Corrective Action: The mine operator installed additional support in the area of the fall. Safety awareness discussions have been conducted on the importance of workplace examinations, emphasizing roof, rib, and floor conditions.



# CONCLUSION

The accident occurred because a localized geologic discontinuity, exposed during mining, was not recognized and adequate precautions to eliminate the hazard were not taken. The victim was struck by a 30-inch x 30-inch x 6-inch piece of roof rock that fell from between the rib and roof bolts.

# ENFORCEMENT ACTIONS

A 104(a) Citation was issued for a violation of 75.202(a).

The operator failed to adequately support or otherwise control the roof (N-0 section, 2-right crosscut) to protect persons from hazards related to falls.

On August 10, 2005, while operating a continuous mining machine, a miner received fatal injuries when a piece of roof rock, 30-inches x 30 inches x 6 inches, fell from between the rib and roof bolt, striking the victim on the head and back. The rock was a localized geologic discontinuity, characterized by smooth contact planes that afforded little adhesion to the immediate roof. This formed an area of natural weakness, constituting a fall of roof hazard. Additional measures, such as additional support and/or scaling, were needed to protect persons working or traveling in the area from this hazard.

# BEST PRACTICES

- Train all miners on the importance of continual roof, face, and rib evaluations and the need to take corrective action as necessary.
- Conduct a thorough visual examination of the roof, face, and ribs immediately before any work is started, and thereafter as conditions warrant.
- Position yourself in a safe area.
- Be alert to changing roof conditions at all times.
- Scale down or support loose material.
- Use supplemental support for immediate roof control such as screen or larger roof bolt plates.